MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION			
Type of Requestor: $(x) HCP$ () IE () IC	Response Timely Filed? (x) Yes () No		
Requestor's Name and Address San Antonio Accident & Injury Center	MDR Tracking No.: M4-04-2411-01		
401 W. Commerce, #100	TWCC No.:		
San Antonio, TX 78207	Injured Employee's Name:		
Respondent's Name and Address City of San Antonio	Date of Injury:		
c/o Harris & Harris P.O. Box 162443	Employer's Name: City of San Antonio		
Austin, TX 78716 Box 42	Insurance Carrier's No.: 0027847456		

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	То	Ci i Couc(s) or Description	Amount in Dispute	Amount Duc
06/10/03	06/30/03	CPT Codes: 99213, 97032, 97124, 97116, 97112, 97265,	\$1,428.00	\$384.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 09/08/03 states in part, "...The bills were denied because payment was reduced because the documentation does not state what area was treated. It also states the claim does not include treatment to the cervical and/or thoracic areas. The reason why it states treatment does not include cervical and thoracic is because treatment was only done to this patient's shoulder. If treatment had been done to the cervical and thoracic, it would have been noted on the diagnosis code on the HCFA 1500 form. Also, it does not state what area was treated on the soap notes. Apparently, that is why it was being denied..."

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a Position Summary with their response.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 99213 (8 dates of service) for dates of service 06/10/03 06/30/03 denied as "N". Per the 1996 Medical Fee Guideline, E&M Ground Rule (IV)(C)(2) the submitted SOAP notes support the level of service billed. Reimbursement in the amount of \$384.00 (\$48.00 x 8) is recommended.
- CPT Codes 97032, 97124, 97112, 97116 and 97265 for dates of service 06/10/03 06/30/03 denied as "N". Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(9)(a-d) the requestor did not document the physical medicine modalities in the SOAP notes; therefore, MDR cannot confirm the treatment was rendered as billed. Reimbursement is not recommended.

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement in the amount of \$384.00. The Division hereby ORDERS the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.				
		03-04-05		
Authorized Signature	Typed Name	Date of Order		
PART VIII: YOUR RIGHT TO REQUEST A HEARI	ING			
Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute. Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.				
PART IX: INSURANCE CARRIER DELIVERY CER	RTIFICATION			
I hereby verify that I received a copy of this De	cision and Order in the Austin Re			
Signature of Insurance Carrier		Date:		